406 School visits should be an integral part of the CF CNS service

J. Cowlard[1], C. Lambert[1], S.B. Carr[1], C.S. Pao[1]. [1]*Paediatric Respiratory Medicine, Barts and The London Children's Hospital, London, United Kingdom*

Introduction: In 2008 the CNS team visited 40 nurseries and schools, from a caseload of 85 nursery and school age children, to provide basic CF knowledge and information about cross infection and Pseudomonas acquisition. An individualised written management plan was given to each school after the visit.
Aim: To review the effectiveness of our CNS school visit service provided by the CF team from a parent and school perspective using school and parent feedback questionnaires.
Method: An anonymised questionnaire was sent to all schools to evaluate the visit content and frequency of future contact. Parental feedback came from the CF service patient feedback questionnaire.
Results: 23/40 schools have replied to date. Satisfaction was reported on a 4 point scale: very informative to poor. 20/23 schools found the CNS visit very informative whilst 3/23 found it informative. 14/23 found the individualised written summary very informative, 7/23 informative and 2/23 did not receive the written summary or did not respond. 19/23 would like a school visit at the start of the next school year. 19/23 schools remember receiving a"CF and Schools" publication and found this a useful resource.
23/29 families recalled a school visit. 19/23 families remembered being invited to attend school visit. 14/23 knew that an individualised written summery was given to schools and 16/23 would have liked a copy. Out of 40 school visits completed in 2008, 17 parents attended with the CNS.
Conclusion: This study confirms the widely accepted view that school visits are appreciated by parents and schools. What it adds is that schools are so appreciative that they want visits on a yearly basis. However school visits are very time consuming and may not be possible in all CF centres.

407 Telephone calls by CF nurses

R. Panzo[1], L. Agrario[1], C. Dupont[1], N. Desmazes-Dufeu[1], R. Kanaan[1], P.R. Burgel[1], M.J. Nadaud[1], D.J. Dusser[1], D. Hubert[1]. [1]*Adult CF centre, Hôpital Cochin, APHP, Paris, France*

Three CF nurses take care of 340 adult patients with CF at our CF centre. They spend part of their time on the telephone, yet this activity is often not considered as a real part of their duties and has no financial counterpart.
Objective: To check telephone calls in order to identify their number and nature.
Method: All telephone calls, either received or made by the CF nurses, were systematically monitored from March 1 to May 31 and from September 1 to November 30 2008.
Results: 1626 calls were received with an average of 271 calls per month (min 195 – max 350) from: 563 patients (34.6%), 285 medical staff (17.5%), 250 private nurses (15.3%), 187 home IV services (11.5%), 122 pharmacies or medical laboratories (7.5%), 113 relatives (6.9%), 106 others (6.5%). Patients' calls were mainly triggered by acute events (respiratory exacerbation, haemoptysis, pain, need for IV antibiotics, problem with their totally implantable vascular access device) (38.4%) or the need for prescriptions (26.7%). A few patients called for administrative procedures (6.8%) or outpatients appointments (4.5%). In the same period, the CF nurses made 1755 phone calls with an average of 292 per month (min 209 – max 375) to: 408 patients (23.2%), 263 medical staff (14.9%), 300 private nurses (17.1%), 338 home IV services (19.2%), 296 pharmacies or medical laboratories (16.8%), 73 relatives (4.1%), 77 others (4.4%). Most of these calls were linked to the organisation of IV antibiotic courses at home, either straight away, or after the initiation of treatment in the hospital. As a whole, the CF nurses spent an average of 2 hours a day on the phone.
Conclusion: Although time consuming, telephone calls remain crucial for patients for whom the CF nurse is often the first point of contact with the CF centre.

408 The extended role of the CF healthcare professional – is it time to re-evaluate our role?

L.M. MacDougall[1], G. Brady[1], A.J. Marshall[1], A.J. Smith[1], H.C. Rodgers[1]. [1]*CF Unit, Ninewells Hospital, Dundee, United Kingdom*

Background: Since the 1980s CF teams have grown in size and number throughout the UK. The role of the CF team member has traditionally been defined by specific roles such as CF specialist nurse, CF physiotherapist and CF dietitian. However, these roles have changed dramatically over the last 30 years. With the introduction of agenda for change the focus has been on skill sets rather than a defined "role".
Objectives: In this study we looked at the current roles of different CF team member, to determine if they were "traditional" (i.e. Tended to relate to their own specialty with little overlap of skills) or "extended" (i.e. overlapped with the role of others in the team).
Method: In a 4 week period each team member kept a record of tasks completed in relation to their day to day work, and indicated if they felt the task was specific to their role, or extended (could have appropriately have been completed by another team member with training), or generic (anyone could do). They also indicated how confident they felt completing the task (scale 1–4), needs training – fully competent), something to indicate cannot do but would like to learn if training opportunity.
Results: Results will be presented regarding tasks performed by each team member in relation to traditional or extended roles within the team. We will also discuss how the extended role could be further developed for each team member.

409 Use of modified early warning score in adults with Cystic Fibrosis

T. Hughes[1], R. Metcalfe[1], S.P. Conway[1], D. Peckham[1]. [1]*Leeds Adult Cystic Fibrosis Unit, Leeds, United Kingdom*

Modified early warning score (MEWS)is a simple physiological scoring system which identifies patients at risk of clinical deterioration. There is no evidence regarding use of MEWS to identify deterioration in adults with Cystic Fibrosis (CF). We report results of an audit assessing accord between MEWS score/algorithm for action and management by the CF team along with patient outcome.
MEWS was calculated in 101 outpatients and on 332 occasions in 44 inpatients attending the CF unit (acute outpatients, home IVs, inpatients)over one month. Audit documentation was completed: reason for visit, MEWS score, action of clinical team, action suggested by MEWS algorithm, patient outcome.
MEWS score coincided with CF team action in 158 inpatient and 30 outpatient cases. Using MEWS and algorithm, intervention would have been more than that given by the CF team in 26 outpatient and 72 inpatient cases. For example, five outpatients had MEWS scores over five with algorithm suggesting critical care contact, hourly observations, etc. These patients continued home treatment successfully without increased intervention. Conversely in 45 inpatient and 45 outpatient cases MEWS failed to adequately predict clinical deterioration identified by the CF team. Using standard management all patients returned home and did not require intensive care/high dependency intervention.
Implementation of MEWS for people with CF is likely to increase burden of assessment and intervention for some patients. Conversely it may lead to less intervention for some patients compared to standard management. MEWS is unlikely to positively affect patient outcome compared to standard management. Findings coincide with previous reviews of early warning scores which state concern about sensitivity, positive predictive value and impact on clinical outcome.